| | EBAD-2013 |
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| EOD OFFICE LISE ONLY. | Rev. Jan. 13 |
| FOR OFFICE USE ONLY: | 2 Page Form |
| ADDENDUM NUMBER: DATE RECEIVED: | |
| | Y YOU |

SUFFOLK COUNTY BOARD OF ETHICS

335 Yaphank Avenue, Yaphank, New York 11980 · Office 631.852.4038 · Fax 631.852.4041

ADDENDUM TO FINANCIAL DISCLOSURE STATEMENT

Use this form to make any amendment (s) or addition (s) to your filed Financial Disclosure Statement. The original will be attached to your filed statement and a copy will be returned to you stamped received.

Directions: Please complete the table below. Specify the question number and the information to be changed or added. If you are correcting a failure to check a box, please state whichever applies; "box should be checked none" or "box should be checked not applicable." In the event any addendum cannot be submitted in the format below, please attach an additional statement. When you are finished, please complete the attestation on page 2 of this form.

| Question Number | Information to be added or changed |
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ATTESTATION

| Signature Printed Name STATE OF NEW YORK: ss: COUNTY OF SUFFOLK: Sworn to before me this | I hereby certify that I have read the addendum to my Financial Disclosure Statement and that, to the best of my knowledge and be addendum are true, correct and complete. I further any asset, interest or property for the purpose while retaining an equitable interest herein. | nt dated theday elief, my Financial I arther certify that I h | of, 20, Disclosure Statement and this have not and will not transfer |
|--|---|---|--|
| STATE OF NEW YORK: SS: COUNTY OF SUFFOLK: Sworn to before me this day of, 20 Notary Public Affix Stamp: | _ | Signature | |
| SS: COUNTY OF SUFFOLK: Sworn to before me this day of, 20 Notary Public Affix Stamp: | _ | Printed Name | |
| COUNTY OF SUFFOLK: Sworn to before me this day of, 20 Notary Public Affix Stamp: | | | |
| Notary Public Affix Stamp: | | | |
| Affix Stamp: | Sworn to before me this day of _ | | , 20 |
| | Notary Public | | |
| FOR OFFICE USE ONLY | Affix Stamp: | | |
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